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SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS
AND INTERNATIONAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
Fax: 202 225-2382

MEMORANDUM

To: Members of the Subcommittee on National Security, Emerging Threats, and International Relations

From: Christopher Shays
Chairman

Date: August 31, 2006

Re: Briefing memo for September 6, 2006 Subcommittee hearing.

Attached find the briefing memo required by Committee rules for the hearing entitled *HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief?* The hearing will convene September 6, 2006 at 1:00 p.m., room 2154 Rayburn House Office Building in Washington, D.C.

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Fax: 202 225-2382

August 31, 2006

MEMORANDUM

To: Members of the Subcommittee on National Security, Emerging Threats, and International Relations

From: Ms. Elizabeth Daniel, Professional Staff ED

Re: Briefing memo for the hearing *HIV Prevention: How Effective is the President's Emergency Plan for AIDS Relief?* scheduled for September 6, 2006 at 1:00 p.m., room 2154 Rayburn House Office Building in Washington, D.C.

PURPOSE OF THE HEARING

The hearing will examine how funding allocation requirements impact the Human Immunodeficiency Virus (HIV) prevention component of the President's Emergency Plan For AIDS Relief (PEPFAR).

HEARING ISSUES

1. **How does the PEPFAR spending requirement affect the ability of focus countries to effectively implement prevention initiatives?**

2. **What steps can be taken to address concerns about limitations presented by the funding requirement?**

BACKGROUND

In 2003, President Bush launched the largest initiative in history to combat HIV/AIDS (Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome). The President's Emergency Plan for AIDS Relief (PEPFAR)—which was authorized for fiscal years 2004-2008 through the 2003 U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (P.L. 108-25, also known as the Leadership Act)—is a five-year, $15 billion plan designed to help fight the HIV/AIDS epidemic and prevent seven million new infections by 2010 through prevention, treatment, and care interventions. **(Web Resource 1)**

Now entering its fourth year, PEPFAR has come under scrutiny for its focus on HIV prevention through abstinence and faithfulness to what critics see as the marginalization or exclusion of condom use and other preventative measures. This criticism stems from the Leadership Act's requirement that 1/3 of prevention spending go to abstinence-until-marriage initiatives. Advocates of PEPFAR counter that local epidemiology in PEPFAR's focus countries makes a case for prevention via behavior change approaches like education for abstinence and monogamy.

DEVELOPMENT OF THE AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

The diagnosis of AIDS first was announced in a 1981 article that detailed similar strains of unusual pneumonia in five previously healthy patients.[1] In the twenty-five years since, AIDS has ballooned into a vast public health pandemic. At the end of 2005, an estimated 38.6 million people worldwide were living with HIV. That same year, an estimated 4.1 million people newly acquired the virus, and an estimated 2.8 million died of AIDS. **(Web Resource 2)**

Worldwide, programs to prevent HIV acquisition, to treat the disease, and to care for those afflicted have had a broad, if ultimately somewhat limited, impact on the disease:

[1] "Epidemiologic Notes and Reports: *Pneumocystis* Pneumonia --- Los Angeles." *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, June 5, 1981. http://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm.

> Favorable trends in several countries are related to changes in behavior and prevention programs. Changes in incidence along with rising AIDS mortality have caused global HIV *prevalence* (the proportion of people living with HIV) to level off. However, the *numbers* of people living with HIV have continued to rise, due to population growth and, more recently, the life-prolonging effects of antiretroviral therapy. In sub-Saharan Africa, the region with the largest burden of the AIDS epidemic, data also indicate that the HIV incidence rate has peaked in most countries. However, the epidemics in this region are highly diverse and especially severe in southern Africa, where some of the epidemics are still expanding. **(Web Resource 2)**

The AIDS epidemic disproportionately and most severely affects sub-Saharan Africa. Consequently, the United States directs the bulk of its AIDS funding to that part of the continent. Though this region contains only slightly more than 11 percent of the world's population, there are 24.5 million HIV-positive persons there, which translates to roughly 64 percent of the worldwide total of infected persons. According to CRS,

> Experts attribute the severity of Africa's AIDS epidemic to the region's poverty, women's relative lack of empowerment, high rates of male worker migration, and other factors. Health systems are ill-equipped for prevention, diagnosis, and treatment. (As a result, Africans suffer from high rates of untreated sexually-transmitted infections other than AIDS, increasing their susceptibility to HIV.) AIDS' severe social and economic consequences are depriving [sub-Saharan] Africa of skilled workers and teachers, and reducing life expectancy by decades in some countries. There are an estimated 12.3 million African AIDS orphans. They face increased risk of malnutrition and reduced prospects for education. AIDS is blamed for declines in farm production in some countries and is seen as a major contributor to hunger and famine. **(Web Resource 3)**

By January 2000, the U.S. Central Intelligence Agency National Intelligence Estimate suggested a forthcoming demographic catastrophe, depleting up to a quarter of the populations of certain countries. The results would be threefold. Already, average African life expectancy has decreased to 47 years, where it would have been 62 without the impact of the AIDS epidemic. Population decrease first depletes the workforce and devastates national productivity at all levels of the economy, from hard-hit rural

agricultural workers to middle and upper levels of public and private sector management, wiping out production and causing famine. This generates political instability as military soldiers, reportedly already suffering infection rates higher than the general public, and in many cases responsible for domestic peacekeeping and security in the region, become unable to perform their jobs. Devastated economies coupled with insecure political circumstances in turn slow democratic development. **(Web Resource 3)**

GENESIS OF PEPFAR

The United States had directed a portion of its international aid donations to the cause of AIDS in sub-Saharan Africa since the late 1980s, as it became clear this was the most severely affected area of the world.

Through the 1990s, the United States contributed both alone to the global AIDS cause with significant education, prevention and treatment programs through the U.S. Agency for International Development (USAID), and later, in the early 2000s, multilaterally through initiatives like UNAIDS[2] and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Based in Geneva, The Global Fund is an independent, multi-billion dollar foundation designed in the late 1990s and, after a 2001 founding pledge by President Bush of $200 million, established in January 2002. The Global Fund differs from PEPFAR in its multilateral character, contribution to capacity building, and operations in different countries. PEPFAR and the Global Fund are intended to be complementary, rather than competitors, although there has been overlap and competition in the past. Since the inception of the Global Fund, the U.S. government has provided financing to the Fund with resources appropriated through State, USAID, and HHS (Health and Human Services) accounts. Currently, the Office of the Global AIDS Coordinator oversees these funding streams. **(Web Resource 4, Attachment 1)**

In 2003, Congress passed legislation that created the $15 billion President's Emergency Plan for AIDS Relief (PEPFAR), the largest, most

[2] UNAIDS, the Geneva-based Joint United Nations Program on HIV/AIDS, brings together the efforts and resources of ten UN system organizations on the ground in more than 75 countries: UNHCR (UN High Commissioner for Refugees), UNICEF (UN Children's Fund), WFP (World Food Program), UNDP (UN Development Program), UNFPA (UN Population Fund), UNODC (UN Office on Drugs and Crime), ILO (International Labor Organization), UNESCO (UN Educational, Scientific, and Cultural Organization), WHO (World Health Organization) and the World Bank.
http://www.unaids.org/en/AboutUNAIDS/default.asp.

comprehensive such initiative in history. P.L. 108-25, the 2003 U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (also known as the Leadership Act) authorizes PEPFAR as a five-year, $15 billion initiative ultimately affecting 120 nations. With $5 billion in pre-existing commitments for bilateral HIV/AIDS initiatives, the $15 billion represents a $10 billion increase of the total financial U.S. commitment, with $9 billion of it targeted to HIV/AIDS initiatives in 15 "focus countries."

Twelve of these PEPFAR focus countries are in sub-Saharan Africa: Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia; the three others are Guyana, Haiti, and Vietnam. Focus countries receive the bulk of PEPFAR funding, directed toward three umbrella goals:

- Support treatment for 2 million HIV-infected people.
- Prevent 7 million new HIV infections.
- Support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children.

(Web Resource 1)

PEPFAR FUNDING PROCESS

PEPFAR's funding in the focus countries is driven by Country Operational Plans (COPs), produced by focus country teams each fiscal year. Submitted to the Office of the United States Global AIDS Coordinator (OGAC) at the Department of State, COPs outline planned activities and designate implementing partners. After technical, programmatic, and principals' review, revision, and approval, OGAC notifies relevant congressional committees[3] of PEPFAR plans for the coming fiscal year. With congressional approval, funds are transferred to the field for obligation. All implementing partners are instructed to expend their funds within 12 months of receiving them. **(Web Resource 5)**

Funds are disbursed mainly through the State Department's Global HIV/AIDS Initiative (GHAI) account,[4] and to a lesser degree through the

[3] Committees of jurisdiction include the Senate Committee on Foreign Relations, the House Committee on International Relations, and the Senate and House Committees on Appropriations.
[4] A small proportion of funding goes through programs at the Department of Health and Human Services.

Child Survival and Health account, the Prevention of Mother to Child Transmission account, and the Center for Disease Control (CDC) Global AIDS Program.[5] Country teams must submit semiannual and annual progress reports to OGAC each fiscal year to identify obligations that have occurred in the past fiscal year, as well as results of the various activities. **(Web Resource 5)**

THE ABC SPENDING REQUIREMENT

The 2003 Leadership Act which authorized PEPFAR recommends that twenty percent of total PEPFAR funds be spent on HIV prevention. The Leadership Act also endorses what is called the "ABC" model for prevention of sexual transmission of HIV, referring to its policy to "Abstain, Be faithful, or use Condoms."[6] The Leadership Act includes a spending requirement that reflects this belief in ABC.

In August 2005, OGAC (Office of the Global AIDS Coordinator) established policies, according to GAO, "directing 20 country teams to dedicate at least 50 percent of prevention funding to sexual transmission prevention activities, and 66 percent of that amount to AB activities, starting in fiscal year 2006." Significantly, "OGAC also instructed the teams to isolate AB spending in their annual reports to demonstrate adherence to the spending requirement." **(Web Resource 5)**

LEGISLATION

In June 2006, the Protection Against Transmission of HIV for Women and Youth Act of 2006 (PATHWAY Act, H.R. 5674) was introduced in the House. Within the broader context of reducing developing country women's and girls' vulnerability to HIV infection, the bill seeks to lift the abstinence-

[5] The Prevention of Mother to Child Transmission account expired at the end of fiscal year 2004, but some country teams carried over funds from this account from fiscal year 2004 to fiscal year 2005. Therefore, for fiscal year 2006, PEPFAR funding is defined as funds appropriated to the remaining three accounts.

[6] Under PEPFAR there are five prevention program areas—abstinence/faithfulness (AB), "other prevention," prevention of mother-to-child transmission (PMTCT), blood safety, and safe medical injections. These areas are divided into two groups: those aimed at preventing sexual transmission—AB and "other prevention"—and those aimed at preventing nonsexual transmission—PMTCT, blood safety, and safe medical injections. "Other prevention" activities include the purchase and promotion of condoms, management of sexually transmitted infections (if not in a palliative care setting), and messages or programs to reduce injection drug use and related risks.

until-marriage funding earmark from PEPFAR. The bill's purpose is to enable HIV prevention programs to maintain responsiveness to local conditions by allowing the programming of funds towards prevention programs that have been proven to be effective. **(Attachments 2, 3, Web Resource 6)**

DISCUSSION OF THE HEARING ISSUES

1. To what extent does the spending requirement affect the ability of country teams to effectively implement prevention initiatives?

While PEPFAR is praised as U.S. commitment to fighting HIV/AIDS on an unprecedented scale, and country teams have indicated that the ABC model is useful for HIV prevention, the Leadership Act's requirement that 1/3 of prevention funding be directed to AB initiatives has been criticized for restricting capacity to respond to local needs. **(Web Resource 5)**

In April 2006, the Government Accountability Office (GAO) reported that the funding requirement "challenged [country teams'] ability to integrate the components of the ABC model and respond to local needs, local epidemiology, and distinctive social and cultural patterns." Specifically, GAO highlighted the following areas of difficulty for implementers:

- The spending requirement, specifying strict percentages to be spent on AB initiatives, "presents challenges to [focus countries'] ability to respond to local epidemiology and cultural and social norms."

- Exemptions to the 33 percent funding requirement granted some country teams means some other teams must designate more than that ratio to AB in order for the PEPFAR program to maintain the overall 33 percent target.

- Program funding for AB and for C components is segregated, which compromises the integration of ABC activities especially for at-risk groups that need comprehensive messages.

- This funding segregation also limits some country teams' ability to shift program focus to meet changing prevention needs.

Countries that requested exemptions from the AB spending requirement cited one or more of the following in their reasoning, among others:

- Focus on abstinence would have meant a decrease for available funds for Prevention of Mother To Child Transmission (PMTCT).

- AB messages are not relevant for certain high-risk groups, but certain countries with a stronger concentration of such groups felt there was therefore limited funding to deliver appropriate prevention messaging.

- There are differences in need among the focus countries, but rigid funding allocations can mean a lack of responsiveness to cultural and social norms.

(Web Resource 5)

Other critics of PEPFAR's prevention strategy assert that the focus on abstinence and faithfulness, and the isolation of condom education and distribution to high-risk groups like prostitutes and men who have sex with men (MSM), stigmatizes condom use as the domain of societal outcasts. **(Attachments 4, 5)**

The requirement that country teams isolate AB spending in their annual reports has garnered attention because some believe AB isolation hinders integration of all prevention components. In addition, critics charge this isolation allows OGAC to devote a hidden higher percentage of funding to abstinence-until-marriage initiatives. OGAC can make budgets appear a certain way by choosing whether the 33 percent earmark is included in synergized programming or must be recorded solely as discrete abstinence initiatives. OGAC has the option, these critics say, of "counting funds spent on abstinence and delay of sexual debut *within* comprehensive programs toward fulfilling the earmark, or only counting those funds spent on programs *discrete from* comprehensive programs.[7]" This study charts the actual percentages of PEPFAR funding in specific countries directed to AB programming in fiscal years 2004 and 2005. **(Attachment 4, p.4)**

Still others contend that entirely outside the spending requirement, PEPFAR's focus on AB de-emphasizes important areas of HIV prevention, such as providing clean needles to intravenous drug users. Injection drug use is said to account for at least 10 percent of new infections globally (though not primarily in sub-Saharan Africa). **(Attachment 4)**

[7] Emphasis original.

Supporters of the ABC policy counter that it is strongly evidence-based and produces measurable results. In 2003 testimony before the House during hearings for PEPFAR, Dr. Ted Green argued for behavior change approaches to fighting AIDS, consistent with the ABC approach used by PEPFAR today.

> AIDS prevention is largely a behavioral problem that requires a behavioral solution. I believe that AIDS prevention programs in Africa and the developing world generally have become too focused on medical technology and drugs, and not enough on behavior. Evidence from Uganda and some other countries, show that when faced with a life-threatening danger, people can and will modify their behavior, once they are given the right information, in the right way. **(Web Resource 7)**

Cases like that of Uganda have succeeded, Dr. Green has written elsewhere, because an approach to fighting AIDS through behavioral change is relevant and appropriate in an environment like sub-Saharan Africa.

> The dominant prevention paradigm was developed for high-risk groups in US cities like San Francisco. Part of the risk reduction model was to not address sexual behavior. It was argued that this would amount to making value judgments, which is unscientific and would only drive away those who needed to be reached. AIDS experts settled for risk or harm reduction approaches, which assume that behavior is difficult or impossible to change, therefore efforts ought to be made to mitigate the consequences of risky behavior. **(Web Resource 8)**

U.S. Global AIDS Coordinator Ambassador Mark Dybul has widely defended the ABC approach, citing double-digit statistical percentage changes in abstinence practice, faithfulness to a single partner, and condom use in the PEPFAR focus countries. In addition, he points out that the criticism of condoms being de-emphasized is negated by the unprecedented sums of money PEPFAR puts toward condom distribution. **(Web Resource 9)**

The second annual PEPFAR report to Congress addresses the question of prevention strategy integration, noting that the United States "supports the most diverse portfolio of HIV/AIDS prevention activities of any

international partner: the targeted ABC approach…to prevent sexual transmission, and the expansion of programs that focus on mother-to-child transmission, blood safety and safe medical injections, intravenous drug use, HIV-discordant couples, women, men, and alcohol abuse, among other key issues." **(Web Resource 10)**

The GAO report provoked controversy because it was perceived by some as criticizing the Administration. Critics said GAO skewed the outcome of its report because it strayed from the original report request; did not visit the most successful focus countries; omitted recent data on ABC; should have studied countries' pre-PEPFAR conditions; and in the end produced a biased report. GAO countered that it had worked consistently with congressional staff; cited instances of ABC success; conducted research based on a formula that included funding criteria, in consultation with OGAC staff; conducted structured interviews in countries not visited; and was precluded from studying pre-PEPFAR conditions because data does not exist. **(Attachments 6, 7)**

2. What steps can be taken to address concerns about the limitation of the funding requirement?

Critics of PEPFAR's ABC-related funding requirements are largely constructive. Overall, the following suggestions put forth by various commentators of PEPFAR are united by the wish for greater flexibility, determined by local implementers, in responding to local needs.

The Center for Strategic and International Studies (CSIS) Task Force on HIV/AIDS produced a report arguing for greater integration of reproductive health work and HIV/AIDS prevention. The report cites the AB funding earmark as an inhibitor to prevention strategy integration, noting that "the majority of women are infected within monogamous relationships." In addition, the report states, "If PEPFAR prevention programs are overly focused on AB approaches, this often leads women and girls who are sexually active to see no place for themselves in such programs, thus undermining prevention efforts." **(Web Resource 11)**

GAO says evidence from its study argues for greater reporting input from the focus countries:

> Collect information from the country teams each fiscal year on the spending requirement's effect on their HIV sexual transmission prevention programming and provide this information in an annual report to Congress....(including) justifications submitted by country teams requesting exemption from the spending requirement. [...] (Congress should) use this information to assess the extent to which the spending requirement supports the Leadership Act's endorsement of both the ABC model and strong abstinence-until-marriage programs.
>
> **(Web Resource 5)**

By and large, a multi-pronged approach to prevention is seen as a good thing by implementers, who recognize that different segments of the population will require varied approaches to HIV prevention. With greater information sharing and the option for greater flexibility, if necessary, administrators and implementers can work together toward the critically important cause of HIV prevention.

WITNESS TESTIMONY

Witnesses were told the purpose of the hearing is to examine the effectiveness of the HIV prevention component of the President's Emergency Plan For AIDS Relief (PEPFAR).

The Honorable Mark R. Dybul, U.S. Global AIDS Coordinator, and the Honorable Kent Hill, Assistant Administrator for the Bureau of Global Health at USAID, are expected to represent Department of State and USAID perspectives on the formulation behind the PEPFAR funding allocation system, the effectiveness of the ABC model, how funding requirements affect various facets of the HIV prevention programs, and monitoring and evaluation tools of PEPFAR.

Mr. David Gootnick, chief author of the Government Accountability Office (GAO) report on the PEPFAR spending requirement, has been asked to discuss the effects and effectiveness of this requirement and of the ABC model in PEPFAR HIV prevention programming.

Dr. Helene D. Gayle, President and CEO of CARE USA, has been asked to discuss the work of CARE under PEPFAR, the effect of PEPFAR spending requirements on effective HIV prevention, PEPFAR monitoring and evaluation, and recommendations for improving the requirement.

Dr. Lucy Sawere Nkya, Member of Parliament in Tanzania and founder and head of the Faraja Trust Fund, will testify on how PEPFAR requires her clinic allocate funding, what effects this has on HIV prevention programming, effectiveness of the ABC model, and recommendations for changes in spending requirements.

Dr. Edward C. Green of the Harvard Center for Population and Development Studies has been asked to discuss the effectiveness of the PEPFAR ABC model across different national cultures, methods of monitoring and evaluation, effects of the spending requirement, and recommended funding or structural improvements to PEPFAR.

WITNESSES

Panel One

The Honorable Mark R. Dybul
U.S. Global AIDS Coordinator
U.S. Department of State

The Honorable Kent Hill
Assistant Administrator
Bureau for Global Health
United States Agency for International Development

Panel Two

Dr. David Gootnick
Director, International Affairs and Trade
Government Accountability Office

Dr. Helene Gayle
President and Chief Executive Officer
CARE USA

Dr. Lucy Sawere Nkya
Member of Tanzanian Parliament (MP, Women Special Seats)
Medical Chairperson, Medical Board of St. Mary's Hospital Morogoro
Director, Faraja Trust Fund

Dr. Edward C. Green
Senior Research Scientist
Harvard Center for Population and Development Studies
Director, AIDS Prevention Research Project at Harvard University

ATTACHMENTS

1. "Is PEPFAR Competing or Cooperating in Treatment Scale-Up?" Theo Smart, Aidsmap News, 6/23/06.

2. "Help Reduce Women's Vulnerability to HIV: Take the PATHWAY to a Comprehensive Prevention Strategy." Dear Colleague letter from Rep. Barbara Lee, June 23, 2006.

3. "Rep. Barbara Lee Introduces Landmark Legislation to Stop the Spread of HIV Among Women and Girls Worldwide." U.S. Newswire, June 22, 2006.

4. "Prevention Funding Under The President's Emergency Plan For AIDS Relief: Law, Policy, and Interpretation." Policy Brief, Center for Health and Gender Equity, December 2005.

5. "U.S. Ambassadors Voice Concerns About HIV/AIDS Programs at Recent PEPFAR Meeting." Medical News Today, June 22, 2006.

6. Letter from Rep. Mark E. Souder, Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform to The Honorable David M. Walker, Comptroller General of the United States, April 4, 2006.

7. Letter from The Honorable David M. Walker, Comptroller General of the United States to Rep. Mark E. Souder, Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, April 21, 2006.

WEB RESOURCES

1. U.S. Agency for International Development (USAID) Human Immunodeficiency Virus (HIV) Acquired Immunodeficiency Syndrome (AIDS): President's Emergency Plan For AIDS Relief (PEPFAR)
   http://www.usaid.gov/our_work/global_health/aids/pepfar.html

2. UNAIDS 2006 Report on the Global AIDS Epidemic. Executive Summary. http://www.who.int/hiv/mediacentre/2006_GR-ExecutiveSummary_en.pdf

3. Congressional Research Service (CRS): AIDS in Africa. July 27, 2006. RL33584. http://www.congress.gov/erp/rl/pdf/RL33584.pdf

4. CRS: The Global Fund and PEPFAR in U.S. International Policy. November 3, 2005. RL 33135. http://www.congress.gov/erp/rl/pdf/RL33135.pdf

5. Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief. Government Accountability Office, April 2006. GAO-06-395. http://www.gao.gov/new.items/d06395.pdf

6. Protection Against Transmission of HIV for Women and Youth Act of 2006. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h5674ih.txt.pdf.

7. Prepared Witness Testimony by Edward C. Green for the House Committee on Energy and Resources Subcommittee on Health, March 20, 2003. http://energycommerce.house.gov/108/Hearings/03202003hearing832/Green1379.htm

8. "Dialogue on AIDS Prevention." Edward C. Green. Available at Share the World's Resources. http://www.stwr.net/content/view/105/37/

9. "Ask the State Department." Hosted by Dr. Mark Dybul, 4/13/06. http://www.state.gov/r/pa/ei/64364.htm

10. Action Today, A Foundation For Tomorrow: Second Annual Report to Congress on the President's Emergency Plan For AIDS Relief. http://www.state.gov/s/gac/rl/c16742.htm

11. "Integrating Reproductive Health and HIV/AIDS Programs: Strategic Opportunities for PEPFAR." J. Stephen Morrison and Janet Fleischman, July 2006. http://www.csis.org/media/csis/pubs/060712_hivaids.pdf